VINTON-SHELLSBURG COMMUNITY SCHOOL DISTRICT

PHYSICAL EXAMINATION for 4-5 year olds (To be completed by a physician)

Child's Full Name:_____Birthdate_____

Parent's Names:_____

Age:_____ Height_____ Weight_____ BMI_____

Head and Scalp_____

Eyes:_____ Vision R_____ L_____ Both_____ Vision Referral_____

Nose:_____ Sinus Concerns_____

Ears:_____ R TM_____ L TM_____ Hearing Test: R_____ L_____ Referral_____

Mouth: Gingiva_____Palate_____ Oropharynx_____

Dental Screening required if not completed by dentist_____

Dental Referral_____

Neck:_____ Lymph Nodes:_____

Chest:_____Heart:_____

Apical Pulse:_____ Blood Pressure_____

Lungs:_____ Respirations:_____

Abdomen:_____

Genitalia:_____ Urinary Concerns:_____

Urinalysis:_____

Rectum/Anus:_____ Bowel Concerns:_____

Spine/Back_____ Extremities:_____

Neuromuscular:_____ Gait:_____

Developmental:_____Referral:_____

Blood Lead test required if not previously tested_____

Hemoglobin/Hematocrit_____ Tuberculin Screening_____

History of surgery and injuries:_____

_____

Immunization Administered and Form Completed_____

Summary of findings and recommendations:_____

Treatment or Medications:_____

I have examined _____ , he/she is physically and emotionally able to participate in your program.

Signature of Physician_____ Date:_____